more acceptable, as it is brief, focused, and entails mastering only a limited set of skills.

Despite the growing evidence base supporting these exciting innovations, access to psychological treatments remains an exception. One unique exemplar of scaling up these treatments is the UK's Improving Access to Psychological Treatments (IAPT). IAPT services treat more than 537,000 patients with depression and anxiety annually, train non-specialist providers and specialists with brief accredited courses, and assess the progress of almost all (98%) patients using a unique monitoring outcome system[10]. Their results show that stepped care models of delivery are clinically effective, facilitate short wait times to improve patient attendance, and ultimately increase collaboration between therapists and patients.

In order to integrate and optimize new models of delivery beyond a mental health specialist providing individual care, we must develop, implement and evaluate stepped care systems. As demonstrated by IAPT, this model of care would consist of two levels: an entry, low-intensity step (Step 1) for the majority of patients with mild to moderate symptoms; and a high-intensity step (Step 2) for the minority of patients suffering from severe symptoms and those who do not respond to the first step.

Step 1 would involve either guided self-care or non-specialist professionals performing a range of tasks such as screening, delivering brief evidence-based psychological treatments, and acting as case managers to link the patient, family physician and specialists from mental health or other disciplines. In Step 2, mental health specialists would treat the more severe spectrum of these disorders, monitor use and adherence to medication when appropriate, and ensure treatment quality by training and supervising non-specialist professionals.

This stepped care model emphasizes patient-centered approaches and collaboration with local communities. This includes receiving input on how treatment could be best delivered in order to reduce administrative barriers, and engaging patient advocates in planning and improving the navigation of existing systems. In addition, we can target relevant co-occurring risk factors through integrated health programmes such as parenting platforms, chronic disease interventions and community-based care. In doing so, we may also have the opportunity to reach marginalized groups who may not typically seek mental health care.

We call on the mental health community at large to embrace these evidence-based strategies into routine health care delivery platforms, as a cost-effective approach to reducing the astonishingly large treatment gap for common mental disorders worldwide.

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Progress in developing a classification of personality disorders for ICD-11

In appointing a Working Group charged with developing recommendations in the area of personality disorders (PDs) for the ICD-11, the World Health Organization (WHO) Department of Mental Health and Substance Abuse highlighted several problems with the classification of PDs in the ICD-10.

First, PDs appeared to be substantially underdiagnosed relative to their prevalence among individuals with other mental disorders. Second, of the ten specific PDs, only two (emotionally unstable personality disorder, borderline type and dissocial personality disorder) were recorded with any frequency in publicly available databases. Third, rates of co-occurrence were extremely high, with most individuals with severe disorders meeting the requirements for multiple PDs. Fourth, the typical description of PD as persistent across many years was inconsistent with available evidence about its lack of temporal stability.

The WHO, therefore, asked the Working Group to consider changes in the basic conceptualization of PDs and specifically to explore the utility and feasibility of a dimensional approach. At the same time, the WHO emphasized that any classification system of PDs for the ICD-11 must be usable and useful for health care workers in lower-resource settings who are not highly trained specialist mental health professionals[1].

The Working Group, under the leadership of P. Tyrer, took the WHO's requests very seriously in developing its proposal for ICD-11. PD was conceptualized in terms of a general dimension of severity, continuous with normal personality variation and

sub-threshold personality difficulty. After meeting the general requirements for a diagnosis of PD, an individual would be assigned a mild, moderate or severe PD diagnosis, based primarily on the extent of interpersonal dysfunction and the risk of harm to self or others. The ICD-10 specific PDs were abandoned entirely in favour of five broad trait domains grounded in the scientific literature on personality[2]: negative affectivity, disinhibition, detachment, dissociality and anankastia.

Descriptions of the Working Group proposal were subsequently published in specialty and more general scientific journals[3,4]. It should be noted that, although the essence of the ICD-11 proposal was conceptually compatible with what came to be the "alternative model" of PD diagnosis in the DSM-5, the Working Group recommended against adoption of that model for ICD-11 because it was seen as too complicated for implementation in most clinical settings around the world.

The WHO became aware of significant concerns among some members of the practice community and some PD researchers about various aspects of the proposal. This led to a meeting of the WHO with representatives from the European Society for the Study of Personality Disorders (ESSPD), the International Society for the Study of Personality Disorders (ISPPD), and the North American Society for the Study of Personality Disorders (NASSPD). A description of the concerns of members of the leadership of these organizations about the original Working Group proposal has recently been published[5], although these concerns were not universal[6]. Nevertheless, the WHO believed it was important to attempt to engage a process that would help to avoid further divisiveness and acrimony in this area.

The WHO thus convened a Task Group consisting of members appointed by ISSPD/ESSPD/NASSPD and members of the original Working Group, which was asked to develop recommendations for responding to the concerns. Through discussions over several months, it became clear that the ISSPD/ESSPD/NASSPD representatives were willing to accept a dimensional model of PDs, but felt that the one that had been proposed provided insufficient information about the nature of individual personality disturbance to support case conceptualization, treatment selection, and management.

The other major issue to be addressed was the diagnostic status of borderline PD. Some research suggests that borderline PD is not an independently valid category, but rather a heterogeneous marker for PD severity[7,8]. Other researchers view borderline PD as a valid and distinct clinical entity, and claim that 50 years of research support the validity of the category[9]. Many – though by no means all – clinicians appear to be aligned with the latter position. In the absence of more definitive data, there seemed to be little hope of accommodating these opposing views. However, the WHO took seriously the concerns being expressed that access to services for patients with borderline PD, which has increasingly been achieved in some countries based on arguments of treatment efficacy, might be seriously undermined.

In September 2017, the Task Group held a face-to-face meeting in Heidelberg, Germany, with the leadership and support of S.C. Herpertz, then ISSPD President. The purpose of the meeting was to develop specific proposals for modifications to the ICD-11 guidelines that would address the issues of concern. The main recommended changes were as follows:

- *Systematic incorporation of self functioning in the core diagnostic guidelines for PD.* PD is conceptualized as an enduring disturbance characterized by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction) and/or interpersonal dysfunction.
- *A substantially richer and more clinically informative operationalization of PD severity.* The degree and pervasiveness of disturbances in functioning of aspects of the self; of interpersonal dysfunction across various contexts and relationships (e.g., romantic relationships, school/work, parent-child, family, friendships, peer contexts); of emotional, cognitive and behavioural manifestations of the personality dysfunction; as well as of associated distress or functional impairment should be considered in making a severity determination for individuals who meet the general diagnostic requirements for PD.
- *A substantially richer and more clinically informative operationalization of trait qualifiers.* Each should describe the core feature of the trait domain, followed by a description of the common manifestations of that domain in individuals with PD.
- *A complete description of PD includes the severity rating and the applicable trait domain qualifiers.* The WHO acknowledges that it will not be feasible to conduct such a complete evaluation in all settings.
- *Provision of an optional qualifier for "borderline pattern".* This qualifier may enhance clinical utility by facilitating the identification of individuals who may respond to certain psychotherapeutic treatments. Whether it will provide information that is non-redundant with the trait domain qualifiers is an empirical question.

A revision of the diagnostic guidelines for PDs based on the above recommendations has been approved by the ICD-11 Working Group and the ISSPD/ESSPD/NASSPD representatives. These guidelines are available for review and comment at http://gcp.network, and are now being used in field testing.

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The views expressed in this letter are those of the author and do not necessarily represent the official policies or positions of the WHO. Members of the ICD-11 PD Working Group included P. Tyrer (Chair), R. Blashfield, L.A. Clark (DSM liaison), M. Crawford, A. Farnam, A. Fossati, Y.-R. Kim, N. Koldobsky, D. Lecic-Tosevski, R. Mulder, D. Ndetei and M. Swales. Representatives of ISSPD/ESSPD/NASSPD included S.C. Herpertz, M. Bohus, S.K. Huprich and C. Sharp. The WHO acknowledges the major contributions of L.A. Clark and M.B. First to the revision of the diagnostic guidelines described above.

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Neurocognitive disorders in ICD-11: the debate and its outcome

In the ICD-11, the chapters "06. Mental, behavioural or neurodevelopmental disorders" and "08. Diseases of the nervous system" are going to include, respectively, the groupings of "Neurocognitive disorders" and "Disorders with neurocognitive impairment as a major feature". Concern over the "wrong" allocation of dementias in the diagnostic system had produced many critical reactions from mental health professionals, due to the anticipated adverse consequences for treatment and care. Here we summarize the background and outcome of these reactions.

In late 2016, the World Health Organization (WHO) moved the dementia categories – contrary to the "traditional" location of clinical manifestations in ICD-10 (F00-F03) – from chapter 06 to chapter 08 of the ICD-11 draft. This step, following a Neurology Topic Advisory Group proposal, generated written protest notes by about two dozens of national and international scientific associations, mainly from psychiatry, old age psychiatry, psychology and other mental health workforce. In early 2017, the WHO corrected the previous step in that the dementia categories were moved back to chapter 06.

What was the rationale of these moves? According to the ICD-11 Reference Guide, the guiding principles for "allocation of entities" are "to maintain the structural and functional integrity" of the classification and "to preserve consistency with previous versions". Classification should be changed only with a "strong rationale", and categories should be kept in their "legacy location" if they "could arguably be in two or more places".

Neurocognitive disorders such as Alzheimer dementia are being classified in ICD-10 according to the dagger-asterisk system, with the *clinical manifestation* in chapter F (F00*) and the *aetiology* in chapter G (G30†). In ICD-11, according to this "legacy location", Alzheimer dementia should continue to be classified both in chapter 06 ("disorders") for its manifestation and in chapter 08 ("diseases") for its aetiology, using the new post-coordination coding.

Despite increasing knowledge on aetiopathogenesis and biomarkers, dementias are generally still diagnosed clinically and classified according to their manifestation. The proposal to move them to chapter 08 may have been either misled by concept or misread by the WHO, although the ultimate aim of classifying disease entities is indeed to primarily build on aetiologies and dysfunctional body systems and not solely on clinical manifestations. Despite Griesinger's dictum "mental disease is brain disease"[1], and although involvement of brain dysfunction is increasingly recognized and important to consider, most "mental" disorders cannot be treated as "brain disorders" or diseases with *monocausal* brain pathology.

Arguments against the move of dementias to chapter 08 were referring to WHO managing issues (move contrary to the joint recommendation by Mental Health and Neurology Topic Advisory Groups), conceptual and methodological issues (lack of evidence for the move; the need for a biopsychosocial approach in integrated care), treatment and service issues (resulting limitation of access to care; importance of neuropsychological vs. biomedical measures in treatment and care), professional and interdisciplinary issues (cross-national variation in responsibility of specialties, but usually major role of psychiatrists in treatment and care; importance of keeping the balance among disciplines), economic issues (problems with reimbursement by insurance companies in several countries if dementia is withdrawn from chapter on mental and behavioural disorders), psychopathological issues (behavioural symptoms do not belong in the "neurology" section, while being a major burden for patients and carers and hence a significant focus for treatment), and classification analogies in ICD-11 (e.g., chapters on cardiovascular, infectious and endocrinological diseases).

As an outcome of the debate, the WHO has moved dementias back to mental disorders in chapter 06, analogously to ICD-10 and DSM-5. Chapter 08 covers in its neurocognitive section only "diseases", e.g. Alzheimer disease, which can be associated by post-coordination coding with "6E00 Dementia due to Alzheimer disease". Options for post-coordination coding have now also been implemented for "6D91 Mild neurocognitive disorder" (F06.7 in ICD-10), which can be associated with any of the diseases in chapter 08, or with diseases classified elsewhere, as a result of commentaries by the Japanese Society of Psychiatry and Neurology (JSPN), the German Association of Psychiatry and Psychotherapy, and the American Psychiatric Association.

Another proposal by JSPN was the introduction of specifiers for behavioural symptoms in the diagnosis of dementias, because of their high burden for patients and carers. This has been implemented by the WHO under "6E20 Behavioural or psychological disturbances in dementia".

In conclusion, we have witnessed successful outcomes from a worldwide interactive process with the WHO on classifying neurocognitive disorders taking into account clinical utility[2]. In keeping abreast of the ever developing state of the art, the ICD-11 will need ongoing adaptation, e.g., taking into account the progress in preclinical classification of Alzheimer dementia